



## ***Texas Department of Insurance***

### ***Division of Workers' Compensation***

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4812 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## ***MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION***

### ***GENERAL INFORMATION***

#### **Requestor Name and Address**

PALLADIUM FOR SURGERY  
1100 N EXPRESSWAY STE 3  
BROWNSVILLE TX 78521

DWC Claim #:  
Injured Employee:  
Date of Injury:  
Employer Name:  
Insurance Carrier #:

#### **Respondent Name**

TPS JOINT SELF INS FUNDS

#### **Carrier's Austin Representative Box**

Box Number 11

#### **MFDR Tracking Number**

M4-05-0910-01

#### **MFDR Date Received**

DECEMBER 10, 2003

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Documentation:** None found/provided

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary:** None found/provided

### ***SUMMARY OF FINDINGS***

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 5, 2004	Ambulatory Surgical Services	\$11,387.00	\$0.00

#### **Background**

1. Former 28 Texas Administrative Code §133.305, amended to be effective January 1 2003, 16 *Texas Register* 12282, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. Former 28 Texas Administrative Code §102.5, adopted to be effective July 29, 1991, 16 *Texas Register* 3939; amended to be effective March 15, 1995, 20 *Texas Register* 1418, sets out the guidelines for written communications from the Division, formerly the Commission.
5. Former 28 Texas Administrative Code §133.307, 27 *Texas Register* 12282, effective January 1, 2003, section (I) sets out the procedures for requesting additional documentation from the parties.

## **Finding**

Existing records indicate that the Medical Fee Dispute Resolution (formerly medical review) program docketed a request for medical fee dispute resolution as described in the *General Information* section above. On June 29, 2012, the parties in dispute were notified that the division was unable to locate the physical documentation associated with the aforementioned dispute. This notice was made in the form of a letter which was sent to:

- (1) the requestor via regular mail to the address listed above;
- (2) the respondent via its Austin representative box as listed above.

The division, as required by 28 TAC §102.5 (e) effective for the dates of service in dispute, relied upon information supplied by the requestor or health care provider, and all its known representatives for delivery of the letter. Similarly, the division relied upon the information supplied by the respondent for delivery of the letter to its appropriate Austin carrier representative as required in 28 TAC §102.5 (b).

The letter to the parties included a request for copies of: (1) the original request for dispute resolution; (2) additional information; (3) copies of correspondence; and (4) any additional documentation or information the parties saw fit to provide. Additionally, the party providing documentation was instructed to forward a copy to all other parties at the time it was provided to the division. To date, the division has no record of receiving any responsive documentation from the respondent, requestor, nor from any representatives of the requestor.

28 Texas Administrative Code 133.307(l), 27 Texas Register 12282, effective January 1, 2003, applicable to disputes filed on or after January 1, 2003, states that "The commission may request other additional information from either party to review the medical fee issues in dispute. The other additional information shall be received by the division within 14 days of receipt of this request." The Division requested additional information from carrier with a copy of the request sent to the health care provider on May 31, 2012; however no documentation was provided by either party. Consequently, the Division finds that the requestor has failed to support its request for additional reimbursement.

## **Conclusion**

The division concludes that the requestor has not supported its request for additional reimbursement. For that reason, no additional reimbursement can be recommended.

## ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

## **Authorized Signature**

_____ Signature	_____ Medical Fee Dispute Resolution Officer	April 10, 2013 Date
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## ***YOUR RIGHT TO REQUEST AN APPEAL***

A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**